

Employee Benefits Division

www.ARBenefits.org
This form must be returned to your
Health Insurance Representative; not EBD.

Arkansas State Employees Enrollment Form



	1. Employee Information: (please print)											
Ì	Last Name Home Address			First Name				MI	Gender	☐ Married ☐ Single		
İ				City		8	State	Zip Coo				
	Social Security #:	·			Home #:		Work #:					
	†Primary Care Physician:						Сι	Current patient?				
ſ	2. Dependent Coverage Information: ☐ I decline coverage for my dependents											
s	LAST NAME			FIRST NAME					MI	GENDER		
SPOUSE	Social Security #:			Date of Birth:								
Š E	†Primary Care Physician:					PCP#	Current patient?					
Ъ	LAST NAME			FIRST NAME					MI	GENDER		
D E P 1*	Social Security #:			Date of Birth:				Full time student?**				
1*	†Primary Care Physician:	-	P(PCP#		Current patient?		t?			
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D E P 2*	Social Security #:			Date of Birth:				Full time student?**				
	tPrimary Care Physician:				PCP#			Current patient?				
₽[LAST NAME			FIRST NAME					MI	GENDER		
D E P 3*	Social Security #:			Date of Birth:				Full time student?**				
ັ [tPrimary Care Physician:					PCP#		Current patient?		t?		
₽	LAST NAME		F	FIRST NAME					MI	GENDER		
D E P 4*	Social Security #:	cial Security #:			Date of Birth:			Full time student?**				
	Primary Care Physician:					PCP#		Current patient?		t?		
ſ	2 I Wish To Engall In The Following Dlan.											
3. I Wish To Enroll In The Following Plan:												
	A. Select your level of coverage: Employee Only Employee & Spouse Employee & Children Family				B. Select your plan option: ☐ ARHealth - Health Advantage Network ☐ ARHealth - NovaSys Network ☐ ARHealth HDPPO - NovaSys Network							

[†] ARHealth does not require you to select a Primary Care Physician (PCP) but it is highly recommended. By coordinating your personal health care through a single physician, you can help maintain a consistent level of service with a provider that understands your medical needs and situation.

^{*} Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.

^{**} To be completed for dependents 19 - 24 only. Please submit proof of student status.

4. Other Medical Insuran	 ce:											
2) If Yes, what type of cov If Medicare: Part A Effect If Medicare: Reason for 0	Coverage:	☐ Medicare, ⊢ r Part B Eff D ☐ Disabled	IIC # ate / / □ Kidney Disease									
Please make sure EBD and your carrier has a copy of your Medicare card.												
Covered Person's Name	f you answered Yes to the question above, complete below: (Use additional paper if necessary)											
Covered Person's Name	Coverage Type (single/family) Effective Date Policy Holder's Employer											
Name/Address/Phone/Policy # of Health Ins Co.:												
5. To Be Completed By So	chool District:											
School District #:												
Employee #:	Employee #: Hire Date: Effective Date of Coverage:											
If employee is transferring from	If employee is transferring from another agency/district, please provide name:											
School Business Official	Signature:											
Print Name:												
6. Please Read Before Sign	ning:											
I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.												
AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plant insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plantinsurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of health plantinsurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.												
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit of knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.												
	if I refuse to apply now a request may be deferred											
Employee's Signature: _			Date:									

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